Your activity evaluation should include at minimum, the below questions in some format. Your evaluation may also include other questions that you deem relevant.

|  |
| --- |
| *On a scale of 1-5, please rate the following:* |
| **Program Learning Objectives** | **1-Strongly Disagree** | **2-Disagree** | **3-Neutral**  | **4-Agree** | **5-Strongly Agree** |
| *My participation in this training helped me to:* |
| Learning objective #1  |  |  |  |  |  |
| Learning objective #2 |  |  |  |  |  |
| Learning objective #3  |  |  |  |  |  |

|  |
| --- |
| *On a scale of 1-5, please rate the following:* |
| **Program Effectiveness** | **1-Strongly Disagree** | **2-Disagree** | **3-Neutral**  | **4-Agree** | **5-Strongly Agree** |
| The program met my expectations and learning needs. |  |  |  |  |  |
| The program format was effective. |  |  |  |  |  |
| As a result of participating in this activity, I am confident that I will improve my knowledge, competence, performance, and/or patient outcomes. |  |  |  |  |  |
| I learned skills and concepts that will help me be more effective and strategic in my work. |  |  |  |  |  |
| The program provided me with new ideas and resources. |  |  |  |  |  |

Please describe any specific changes you will make to your practice:

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|  |  |  |
| --- | --- | --- |
| **Perceived Bias** | **Yes** | **No** |
| The program was free of commercial bias |  |  |
| Faculty disclosures were made  |  |  |

If no, please describe comment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based on your participation today, have you identified any barriers when implementing new information or techniques learned in this presentation? Please √ all that applies

* Cost
* Lack of experience
* Lack of resources
* Lack of time to assess/counsel patients
* Technical skills
* Lack of consensus or professional guidelines
* Reimbursement/insurance issues
* Patient compliance issues
* No barriers
* Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify if you are a physician or non-physician (Allied Health Care, Nurse, PA, etc.)

* Physician
* Non-physician